General

Guideline Title

Clinical policy: critical issues in the diagnosis and management of the adult psychiatric patient in the emergency department.

Bibliographic Source(s)

Nazarian DJ, Broder JS, Thiessen ME, Wilson MP, Zun LS, Brown MD, American College of Emergency Physicians. Clinical policy: critical issues in the diagnosis andÂ management of the adult psychiatric patient inÂ the emergency department. Ann Emerg Med. 2017 Apr;69(4):480-98. [39 references] PubMed

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Lukens TW, Wolf SJ, Edlow JA, Shahabuddin S, Allen MH, Currier GW, Jagoda AS, ACEP Clinical Policies Subcommittee (Writing Committee) on Critical Issues [trunc]. Clinical policy: critical issues in the diagnosis and management of the adult psychiatric patient in the emergency department. Ann Emerg Med. 2006 Jan;47(1):79-99. [65 references}

This guideline meets NGC's 2013 (revised) inclusion criteria.

Regulatory Alert

FDA Warning/Regulatory Alert

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory and/or warning information has been released.

- December 14, 2016 – General Anesthetic and Sedation Drugs : The U.S. Food and Drug Administration (FDA) is warning that repeated or lengthy use of general anesthetic and sedation drugs during surgeries or procedures in children younger than 3 years or in pregnant women during their third trimester may affect the development of children's brains. Consistent with animal studies, recent human studies suggest that a single, relatively short exposure to general anesthetic and sedation drugs in infants or toddlers is unlikely to have negative effects on behavior or learning. However, further research is needed to fully characterize how early life anesthetic exposure affects children's brain development.

Recommendations

Major Recommendations

Definitions for the strength of evidence (Class I-III) and strength of recommendations (A-C) are provided at the end of the "Major Recommendations" field.

1. In the alert adult patient presenting to the emergency department (ED) with acute psychiatric symptoms, should routine laboratory tests be used to identify contributory medical conditions (nonpsychiatric disorders)?
   Level A recommendations. None specified.

   Level B recommendations. None specified.

   Level C recommendations. Do not routinely order laboratory testing on patients with acute psychiatric symptoms. Use medical history, previous psychiatric diagnoses, and physician examination to guide testing.

2. In the adult patient with new-onset psychosis without focal neurologic deficit, should brain imaging be obtained acutely?
   Level A recommendations. None specified.

   Level B recommendations. None specified.

   Level C recommendations. Use individual assessment of risk factors to guide brain imaging in the ED for patients with new-onset psychosis without focal neurologic deficit. (Consensus recommendation)

3. In the adult patient presenting to the ED with suicidal ideation, can risk-assessment tools in the ED identify those who are safe for discharge?
   Level A recommendations. None specified.

   Level B recommendations. None specified.

   Level C recommendations. In patients presenting to the ED with suicidal ideation, physicians should not use currently available risk-assessment tools in isolation to identify low-risk patients who are safe for discharge. The best approach to determine risk is an appropriate psychiatric assessment and good clinical judgment, taking patient, family, and community factors into account.

4. In the adult patient presenting to the ED with acute agitation, can ketamine be used safely and effectively?
   Level A recommendations. None specified.

   Level B recommendations. None specified.

   Level C recommendations. Ketamine is one option for immediate sedation of the severely agitated patient who may be violent or aggressive. (Consensus recommendation)

Definitions

Strength of Evidence

*Literature Classification Schema**

Design/Class	Therapy†	Diagnosis‡	Prognosis§
1	Randomized controlled trial or meta-analysis of randomized trials	Prospective cohort using a criterion standard or meta-analysis of prospective studies	Population prospective cohort or meta-analysis of prospective studies
2	Nonrandomized trial	Retrospective observational	Retrospective cohort Case control
3	Case series	Case series	Case series

*Some designs (e.g., surveys) will not fit this schema and should be assessed individually.

†Objective is to measure therapeutic efficacy comparing interventions.

‡Objective is to determine the sensitivity and specificity of diagnostic tests.

§Objective is to predict outcome, including mortality and morbidity.

*Approach to Downgrading Strength of Evidence**

Downgrading	Design/Class		
	1	2	3
None	I	II	III
1 level	II	III	X
2 levels	III	X	X
Fatally flawed	X	X	X

*See the "Description of Methods Used to Analyze the Evidence" field for more information.

Strength of Recommendations

Strength of recommendations regarding each critical question were made by subcommittee members using results from strength of evidence grading, expert opinion, and consensus among subcommittee members according to the following guidelines:

Level A recommendations. Generally accepted principles for patient care that reï¬,ect a high degree of clinical certainty (e.g., based on evidence from 1 or more Class of Evidence I or multiple Class of Evidence II studies).

Level B recommendations. Recommendations for patient care that may identify a particular strategy or range of strategies that reï¬,ect moderate clinical certainty (e.g., based on evidence from 1 or more Class of Evidence II studies or strong consensus of Class of Evidence III studies).

Level C recommendations. Recommendations for patient care that are based on evidence from Class of Evidence III studies or, in the absence of any adequate published literature, based on expert consensus. In instances where consensus recommendations are made, "consensus" is placed in parentheses at the end of the recommendation.

There are certain circumstances in which the recommendations stemming from a body of evidence should not be rated as highly as the individual studies on which they are based. Factors such as heterogeneity of results, uncertainty about effect magnitude and consequences, and publication bias, among others, might lead to such a downgrading of recommendations.

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

- Acute psychiatric symptoms
- New-onset psychosis without focal neurologic deficit
- Suicide ideation
- Acute agitation

Guideline Category

Diagnosis

Evaluation

Management

Risk Assessment

Screening

Treatment

Clinical Specialty

Emergency Medicine

Psychiatry

Intended Users

Physicians

Guideline Objective(s)

- To address key issues for the diagnosis and management of adult psychiatric patients in the emergency department
- To derive evidence-based recommendations to answer the following clinical questions:
  - In the alert adult patient presenting to the emergency department with acute psychiatric symptoms, should routine laboratory tests be used to identify contributory medical conditions (nonpsychiatric disorders)?
  - In the adult patient with new-onset psychosis without focal neurologic deficit, should brain imaging be obtained acutely?
  - In the adult patient presenting to the emergency department with suicidal ideation, can risk-assessment tools in the emergency department identify those who are safe for discharge?
  - In the adult patient presenting to the emergency department with acute agitation, can ketamine be used safely and effectively?

Target Population

Adult patients presenting to the emergency department with psychiatric symptoms

Note: This guideline is not intended to be used for pediatric patients. It is also not intended for patients with delirium in regard to critical questions 1, 2, and 3.

Interventions and Practices Considered

1. Use of medical history, previous psychiatric diagnoses, and physician examination to guide testing
2. Assessment of risk factors to guide brain imaging in patients presenting with new-onset psychosis without focal neurologic deficit
3. Assessment of suicide risk in patients presenting with suicidal ideation
4. Use of ketamine in patients presenting with acute agitation

Note: The following were considered but not recommended: routine laboratory testing and use of risk assessment tools used in isolation.

Major Outcomes Considered

- Sensitivity, specificity, and utility of routine laboratory testing, neuroimaging testing, and available suicide risk-assessment tools in the diagnostic assessment and subsequent management of emergency department (ED) patients with psychiatric complaints
- Suicide attempts or self-harm attempts
- Efficacy of ketamine for sedation of the acutely agitated patient in the ED
- Adverse effects of ketamine

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

This clinical policy was created after careful review and critical analysis of the medical literature and was based on a systematic review of the literature. Searches of MEDLINE, MEDLINE InProcess, Scopus, Web of Science, and the Cochrane Database were performed. All searches were limited to English-language sources, adults, and human studies. Specific key words/phrases, years used in the searches, dates of searches, and study selection are identified under each critical question in the original guideline document. In addition, relevant articles from the bibliographies of included studies and more recent articles identified by committee members and reviewers were included.

Number of Source Documents

Study Selection

Critical Question 1

Ninety-five articles were identified in the searches. Nine articles were selected from the search results for further review, with 2 Class III studies included for this critical question.

Critical Question 2

Ninety-three articles were identified in the searches, and 13 articles were selected from the search results for further review. None of the 13 articles were classified as Class I, II, or III; therefore, zero studies were included for this critical question.

Critical Question 3

Eighty-five articles were identified in the searches. Nineteen articles were selected from the search results for further review, with 4 Class III studies included for this critical question.

Critical Question 4

One hundred thirty-three articles were identified in the searches, and 11 articles were selected from the search results for further review. None of the 11 articles were classified as Class I, II, or III studies; therefore, zero studies were included for this critical question.

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Strength of Evidence

Literature Classification Schema*

Design/Class	Therapy†	Diagnosis‡	Prognosis§
1	Randomized controlled trial or meta-analysis of randomized trials	Prospective cohort using a criterion standard or meta-analysis of prospective studies	Population prospective cohort or meta-analysis of prospective studies
2	Nonrandomized trial	Retrospective observational	Retrospective cohort Case control
3	Case series	Case series	Case series

*Some designs (e.g., surveys) will not fit this schema and should be assessed individually.

†Objective is to measure therapeutic efficacy comparing interventions.

‡Objective is to determine the sensitivity and specificity of diagnostic tests.

§Objective is to predict outcome, including mortality and morbidity.

Approach to Downgrading Strength of Evidence*

Downgrading	Design/Class		
	1	2	3
None	I	II	III
1 level	II	III	X
2 levels	III	X	X
Fatally flawed	X	X	X

*See the "Description of Methods Used to Analyze the Evidence" field for more information.

Methods Used to Analyze the Evidence

Systematic Review with Evidence Tables

Description of the Methods Used to Analyze the Evidence

Assessment of Classes of Evidence

All articles used in the formulation of this clinical policy were graded by at least 2 methodologists and assigned a Class of Evidence. Each article was assigned a design class with design 1 representing the strongest study design and subsequent design classes (i.e., design 2 and design 3) representing respectively weaker study designs for therapeutic, diagnostic, or prognostic clinical reports, or meta-analyses (see the "Rating Scheme for the Strength of the Evidence" field). Articles were then graded on dimensions related to the study's methodological features, such as randomization processes, blinding, allocation concealment, methods of data collection, outcome measures and their assessment, selection and misclassification biases, sample size, and generalizability. Using a predetermined process related to the study's design, methodological quality, and applicability to the critical question, articles received a final Class of Evidence grade (i.e., Class I, Class II, Class III, or Class X) (see the "Rating Scheme for the Strength of the Evidence" field). Articles identified with fatal flaws or that were ultimately not applicable to the critical question received a Class of Evidence grade "X" and were not used in formulating recommendations for this policy. Grading was done with respect to the specific critical questions; thus, the level of evidence for any one study may vary according to the question for which it is being considered. As such, it was possible for a single article to receive different Classes of Evidence as different critical questions were answered from the same study. Question-specific Classes of Evidence grading may be found in the Evidentiary Table in the original guideline document.

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

This policy is a product of the American College of Emergency Physicians (ACEP) clinical policy development process, including expert review, and is based on the existing literature; where literature was not available, consensus of emergency physicians was used.

When possible, clinically oriented statistics (e.g., likelihood ratios [LRs], number needed to treat) are presented to help the reader better understand how the results may be applied to the individual patient. For a definition of these statistical concepts, see Appendix C in the original guideline document.

Rating Scheme for the Strength of the Recommendations

Strength of Recommendations

Strength of recommendations regarding each critical question were made by subcommittee members using results from strength of evidence grading, expert opinion, and consensus among subcommittee members according to the following guidelines:

Level A recommendations. Generally accepted principles for patient care that reï¬,ect a high degree of clinical certainty (e.g., based on evidence from 1 or more Class of Evidence I or multiple Class of Evidence II studies).

Level B recommendations. Recommendations for patient care that may identify a particular strategy or range of strategies that reï¬,ect moderate clinical certainty (e.g., based on evidence from 1 or more Class of Evidence II studies or strong consensus of Class of Evidence III studies).

Level C recommendations. Recommendations for patient care that are based on evidence from Class of Evidence III studies or, in the absence of any adequate published literature, based on expert consensus. In instances where consensus recommendations are made, "consensus" is placed in parentheses at the end of the recommendation.

There are certain circumstances in which the recommendations stemming from a body of evidence should not be rated as highly as the individual studies on which they are based. Factors such as heterogeneity of results, uncertainty about effect magnitude and consequences, and publication bias, among others, might lead to such a downgrading of recommendations.

Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

Expert review comments were received from emergency physicians, psychiatrists, members of the American Association for Emergency Psychiatry and the American Association of Community Psychiatrists, and American College of Emergency Physicians' (ACEP's) Medical Legal Committee. Comments were received during a 60-day open comment period, with notices of the comment period sent in an e-mail to ACEP members, published in *EM Today*, and posted on the ACEP Web site. The responses were used to further refine and enhance this policy; however, the responses do not imply endorsement of this clinical policy.

This clinical policy was approved by the ACEP Board of Directors on January 19, 2017.

This guideline was endorsed by the Emergency Nurses Association on February 27, 2017.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified and graded for each recommendation (see the "Major Recommendations" field).

Recommendations for question 1 were based on 2 Class III studies. Recommendations for question 3 were based on 4 Class III studies. Recommendations for questions 2 and 4 were based on expert consensus.

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

See the "Potential Benefits" sections in Appendix D in the original guideline document for information on potential benefits of the specific interventions.

Potential Harms

See the "Potential Harms" sections in Appendix D in the original guideline document for information on potential harms of the specific interventions.

Qualifying Statements

Qualifying Statements

- Policy statements and clinical policies are the official policies of the American College of Emergency Physicians (ACEP) and, as such, are not subject to the same peer review process as articles appearing in the journal. Policy statements and clinical policies of ACEP do not necessarily reflect the policies and beliefs of *Annals of Emergency Medicine* and its editors.
- This policy is not intended to be a complete manual on the diagnosis and management of adult psychiatric patients in the ED but rather a focused examination of critical issues that have particular relevance to the current practice of emergency medicine.
- It is the goal of the Clinical Policies Committee to provide an evidence-based recommendation when the medical literature provides enough quality information to answer a critical question. When the medical literature does not contain adequate empirical data to answer a critical question, the members of the Clinical Policies Committee believe that it is equally important to alert emergency physicians to this fact.
- This clinical policy is not intended to represent a legal standard of care for emergency physicians. Recommendations offered in this policy are not intended to represent the only diagnostic or management options available to the emergency physician. ACEP recognizes the importance of the individual physician's judgment and patient preferences. This guideline defines for the physician those strategies for which medical literature exists to provide support for answers to the critical questions addressed in this policy.

Implementation of the Guideline

Description of Implementation Strategy

An implementation strategy was not provided.

Implementation Tools

Mobile Device Resources

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Getting Better

IOM Domain

Effectiveness

Patient-centeredness

Safety

Timeliness

Identifying Information and Availability

Bibliographic Source(s)

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Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2017 Apr

Guideline Developer(s)

American College of Emergency Physicians - Medical Specialty Society

Source(s) of Funding

The American College of Emergency Physicians was the funding source for this clinical policy.

Guideline Committee

American College of Emergency Physicians (ACEP) Clinical Policies Subcommittee (Writing Committee) on the Adult Psychiatric Patient

ACEP Clinical Policies Committee (Oversight Committee)

Composition of Group That Authored the Guideline

Members of the Subcommittee (Writing Committee) on the Adult Psychiatric Patient: Devorah J. Nazarian, MD (*Subcommittee Chair*); Joshua S. Broder, MD; Molly E. W. Thiessen, MD; Michael P. Wilson, MD, PhD; Leslie S. Zun, MD, MBA (*Representative from the American Association for Emergency Psychiatry*); Michael D. Brown, MD, MSc (*Committee Chair*)

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Financial Disclosures/Conflicts of Interest

Relevant industry relationships: There were no relevant industry relationships disclosed by the subcommittee members for this topic.

Relevant industry relationships are those relationships with companies associated with products or services that significantly impact the specific aspect of disease addressed in the critical question.

Guideline Endorser(s)

Emergency Nurses Association - Professional Association

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Lukens TW, Wolf SJ, Edlow JA, Shahabuddin S, Allen MH, Currier GW, Jagoda AS, ACEP Clinical Policies Subcommittee (Writing Committee) on Critical Issues [trunc]. Clinical policy: critical issues in the diagnosis and management of the adult psychiatric patient in the emergency department. Ann Emerg Med. 2006 Jan;47(1):79-99. [65 references}

This guideline meets NGC's 2013 (revised) inclusion criteria.

Guideline Availability

Available from the American College of Emergency Physicians (ACEP) Web site .

A summary of this guideline optimized for mobile viewing is available under the CQ tab at the ACEP Web site .

Availability of Companion Documents

The following are available:

- American College of Emergency Physicians clinical policy development. Irving (TX): American College of Emergency Physicians (ACEP); 3 p. Available from the American College of Emergency Physicians (ACEP) Web site .
- ACEP clinical policy development process. Flow chart. Irving (TX): American College of Emergency Physicians (ACEP); 1 p. Available from the ACEP Web site .

Patient Resources

None available

NGC Status

This NGC summary was completed by ECRI on February 13, 2006. The information was verified by the guideline developer on April 6, 2006. This summary was updated by ECRI Institute on October 2, 2007, following the U.S. Food and Drug Administration (FDA) advisory on Haloperidol. This summary was updated by ECRI Institute on May 1, 2009 following the U.S. Food and Drug Administration advisory on antiepileptic drugs. This summary was updated by ECRI Institute on May 20, 2011 following the U.S. Food and Drug Administration advisory on antipsychotic drugs. This summary was updated by ECRI Institute on May 1, 2017. The updated information was verified by the guideline

developer on May 11, 2017.

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